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The inpatient psychiatric unit as both a safe and unsafe place: Implications for absconding

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ABSTRACT

Absconding from acute psychiatric inpatient units is a significant issue with serious social, economic, and emotional costs. A qualitative study was undertaken to explore the experiences of people (n = 12) who had been held involuntarily under the local mental health act in an Australian inpatient psychiatric unit, and who had absconded (or attempted to abscond) during this time. The aim of the study was to explore why people abscond from psychiatric inpatient units, drawing on published work from health geography on the significance of the person–place encounter, and in particular the concept of 'therapeutic landscapes'. The findings show that the inpatient unit is perceived as a safe or unsafe place, dependent on the dialectical relationship between the physical, individual, social, and symbolic aspects of the unit. Consumers absconded when the unit was perceived as unsafe. Forming a therapeutic relationship with staff, familiarity with the unit, a comfortable environment, and positive experiences with other consumers all supported perceptions that the unit was safe, decreasing the likelihood of absconding. Findings extend existing work on the person–place encounter within psychiatric inpatient units, and bring new knowledge about the reasons why consumers abscond. Implications for practice are discussed.

Key words: absconding, Australia, hospitals, inpatients, psychiatric, qualitative research.

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Introduction

Mental health care in Australia, as in many countries, is characterized by deinstitutionalization, where the delivery of care for people with mental health problems has moved from long-stay 'asylums' to community-based care. Where inpatient care is required, this is increasingly delivered within general hospitals with specialist psychiatric units, which remain an important place of care for people with mental health problems (Carr *et al*. 2008).

According to Bowers's (2005) review of the published work, there are seven main reasons for admission to psychiatric inpatient units: (i) being deemed a danger to self or others; (ii) psychiatric assessment; (iii) medical treatment; (iv) having a severe mental disorder; (v) self-care deficits; (vi) respite for the carer; and (vii) respite for the consumer. Due to pressure on inpatient psychiatric services, only the most severely unwell (often with psychotic disorders) are admitted for treatment. Absconding (leaving the hospital without permission) has been identified as a serious issue, with significant social, economic, and emotional costs (Muir-Cochrane & Mosel 2008; Muir-Cochrane *et al*. 2011).

According to a review of the published work by Muir- Cochrane and Mosel (2008), absconding rates vary widely internationally with rates between 2.5% and 34% of all psychiatric admissions, with a recent Australian study citing a rate of 13% (Mosel *et al*. 2010). There are many reasons for absconding reported in the published work. These include: feeling fearful, isolated, and homesick; being concerned about issues at home; having a lack of insight into the need for hospitalization; a disturbing ward environment; boredom; poor quality food; and lack of privacy (Bowers *et al*. 1999; 2000; Carr 2006; Manchester *et al*. 1997; Meehan *et al*. 1999; Nurjannah *et al*. 2009). Feeling fearful while in hospital, in particular, is a phenomenon widely reported by previous studies of consumers' experiences of acute psychiatric units, with evidence of theft of personal property, physical and psychological threats, actual violence, and sexual harassment (Jones *et al*. 2010; National Patient Safety Agency 2006; Quirk *et al*. 2004; 2006; Royal College of Psychiatrists 2006).

Jones *et al*. (2010) interviewed 60 psychiatric inpatients across 60 different psychiatric units in England. The majority of respondents reported feeling safe while in hospital and valued the support from staff and peer support from fellow consumers, yet psychiatric units were also perceived to be 'risky' places with reported incidents of theft, violence, intimidation, and bullying, and alcohol and drug use. These findings are in keeping with the research of Quirk *et al*. (2004; 2006) who conducted an ethnographic study of life on the ward in three acute psychiatric units in London. Quirk *et al*. (2004; 2006) describe the permeability of modern psychiatric units, which contrasts with the impermeability of the old

asylums. This permeability can be seen in the temporary nature of ward membership, and the maintenance of contact with the outside world, for example, resulting in the introduction of illicit substances into the ward environment.

In this paper, we explore why people abscond from inpatient psychiatric units, and how this is related to the notion of the psychiatric unit as a 'risky' environment. The analysis is broadly located within the field of mental health geography (Parr 2000; Philo & Wolch 2001; Wolch & Philo 2000), which is concerned with 'how space, place, environment and landscape impact upon people with mental health problems' (Philo 1997; p. 73), and focuses on the meanings and experiential aspects of place, as well as on the ways in which place actively constitutes and shapes individuals and their interactions. In particular, we draw on published work from health geography on 'therapeutic landscapes' to explore the role of the physical, individual, symbolic, and social aspects of the psychiatric unit, and how these characteristics can influence patients' decisions whether to abscond from inpatient psychiatric care.

Therapeutic landscapes

The notion of therapeutic landscapes is a central theoretical concept within health geography (Moon 2009). Originally introduced by Gesler (1992), and further developed over the past two decades, the therapeutic landscape concept 'provides a framework for analysis of natural and built, social, and symbolic environments as they contribute to healing and well-being in places – broadly termed landscapes' (Williams 2007; p. 2). Early work on therapeutic landscapes tended to focus on the aspects of particular landscapes (such as spas and nature) that were conducive to or associated with healing. In this paper, we focus instead on 'the relational dynamic of person and place' (Cutchin *et al*. 2010; p. 119), and how this might induce, or even fail to induce, positive benefits for health or well-being (Conradson 2005). The therapeutic landscape approach recognizes that 'there is a mutually reinforcing and reciprocal relationship between people and place' (Cummins *et al*. 2007; p. 1825).

The formation of therapeutic landscapes is a dynamic process shaped by the dialectical relationship between three major elements of place. These are as follows (using examples from the present study): 'locale' (the setting in which social relations are constituted, such as the psychiatric inpatient unit); 'location' (broader social and economic processes and how they impact upon the provision of mental health care in this locale); and sense of place (the meanings people attach to the psychiatric inpatient unit) (see Burges *et al*. 2007; Poland *et al*. 2005). By focusing on the relational aspects of the person, place, and

(mental) well-being, the emphasis is on the person–place encounter rather than on the therapeutic landscape as a pre-existing entity (Cutchin *et al*. 2010). From this perspective, the psychiatric inpatient unit is not viewed as intrinsically therapeutic; rather, it is in the mutually-constitutive relationship between the individual and the multiple facets of the hospital landscape (physical, social, symbolic) that well-being may be experienced.

Therapeutic landscapes have received limited attention within mental health geography, with few studies drawing on this framework. Milligan and Bingley (2007) explored the impact of woodland on young adults' mental wellbeing. They found that woodland was experienced as both restorative and scary, suggesting that natural environments should not be assumed to be intrinsically therapeutic. Research has also been conducted into the inpatient psychiatric unit as a therapeutic landscape. Curtis *et al*. (2007), for example, applied this concept to the exploration of aspects of hospital design that are important to the well-being of staff and users. The therapeutic landscape perspective provides a useful framework to understand why consumers abscond, because of its attention to the multiple features of landscapes (physical, social, symbolic, individual) that could impact on absconding behaviour (Yamanis *et al*. 2010).

Methods

Aim

A small-scale, qualitative study was undertaken to explore the experiences of people who had been held involuntarily under the local mental health act in an Australian inpatient psychiatric unit, and who had absconded or attempted to abscond.

Recruitment

Purposeful sampling was used to recruit consumers of mental health services in a metropolitan city in Australia who had some experience with absconding from an inpatient psychiatric unit (either had successfully absconded or had tried to abscond). Information about the study was disseminated via flyers placed within a community-based, not-for-profit organization that delivers programs and services to people affected by mental illness. Consumers were invited to contact the researchers if they were interested in participating in a one-on-one in-depth interview to explore their experiences and perceptions of absconding. Recruitment continued until data saturation was reached.

Sample

Twelve consumers participated in interviews. There were four men and eight women. All consumers had experiences as an inpatient in an acute psychiatric unit (open and closed wards) and had attempted to or succeeded in absconding during their admission. No demographic information was collected as it was thought that this would be too invasive considering the sensitivity of the questioning, and given the exploratory rather than comparative nature of the study; however, all consumers were over the age of 18 years.

Data collection

Interviews were conducted over a 6-month period at the premises of the not-for-profit organization through which consumers were recruited. The interviews were semi-structured with open-ended questions to allow consumers to discuss their experiences of absconding and the reasons they did so. The interviews were audio recorded with the consent of the consumers and transcribed verbatim. The average length of the interviews was 20–40 min.

Ethical considerations

Ethical approval for the study was sought and granted by the relevant university ethics committee. Given the sensitive nature of the topic, consumers were given the opportunity to have a support person present in the interview. Two consumers chose this option. Consumers were informed in the information sheet and at the start of the interview that their participation was voluntary, that they could withdraw from the study at any time without penalty, and that they would not be identified in the interview transcripts or in any reports, publications, or presentations arising from the study. All consumers signed a consent form.

Analysis

A thematic analysis method was chosen to allow vigorous analysis through developing concepts, themes, and meanings, representing a level of patterned response from the dataset (Braun & Clarke 2006). The interview transcripts were analyzed following the procedures outlined by Braun and Clarke (2006) using their 15-point checklist of criteria for effective thematic analysis. Data were imported into computer software (NVIVO qualitative data analysis software, Version 8, 2008; QSR International Pty Ltd, Melbourne, Victoria, Australia) where a staged analysis was undertaken by members of the research team. The team met to determine initial nodes, which were then sorted into potential categories and, finally, themes. The categories and themes were developed collectively in analysis

workshops with research team members. Member checking of themes was undertaken through return of transcripts for comment with minimal changes made to the findings.

Resultant themes were identified in order to provide information about the individual, social, symbolic, and physical aspects of the hospital that impact on absconding. While there were differences in emphasis between consumers, the themes were discussed by all of the consumers. The overarching theme is the inpatient unit being perceived as a safe or unsafe place, and the impact of individual, social, physical, and symbolic factors on this perception.

Results

The inpatient psychiatric unit was experienced by consumers as both a safe and an unsafe place. The hospital was viewed as a safe place when it provided sanctuary, a caring, nurturing, therapeutic place where consumers were protected from themselves and others:

> So basically I don't like going into the closed ward, but I'm safe . . . I know that if I'm on the street I'll be hitchhiking, I'll be jumping into people's cars, I'll be totally at risk. (Consumer 11.)

However, it was when the inpatient psychiatric unit was experienced as unsafe that the consumers were most likely to abscond. In what follows, we describe the individual, social, symbolic, and physical aspects of the inpatient psychiatric unit and their impact on absconding. While these aspects are presented separately, in fact they operate in a dialectical relationship where each affects the other. In particular, it is through the interaction between the consumer's personal experiences of mental illness, the care provided to them while in hospital, their interactions with other consumers, and symbolic and physical factors associated with the hospital environment that consumers experience the hospital as safe/unsafe.

Individual factors

The interaction between experiencing serious mental illness and the hospital environment impacted on consumers' perceptions of the hospital as a safe place. They described feelings of panic and fear leading to absconding, for example, as a result of experiencing hallucinations and paranoia during their admission to an inpatient psychiatric unit:

> I absconded during a kind of psychotic panic attack . . . I don't really know what it was, but I freaked out because I was hallucinating that there was someone in the room and I couldn't make them go away so I just . . . ran down the road. (Consumer 3.)

In addition, consumers described the intense fear resulting from admission to hospital when they were in denial about having a mental illness, and therefore confused and frightened about why they were being hospitalized and medicated:

> . . . I suppose part of it is denial, it wasn't quite clear what my diagnosis was . . . so there was a denial there in relation to that . . . and I'd never been one for confined spaces and hospitals, it just made me feel terrible . . . I just wanted to get out of there. (Consumer 6.)

While in retrospect the consumers viewed these responses as 'irrational', at the time absconding was a justifiable response to a frightening situation. For example:

> All the times that I absconded was based on the same thing but you're not thinking rationally . . . your first interpretation is . . . I've got to get the hell out of here, they're after me. (Consumer 5.)

Consumers also on occasion reported a shift in their perception of the unit from unsafe to safe. For example:

> . . . I felt safer and I felt more secure, I mean I didn't like being in a lock-up ward but as I got more insight I could recognize that that was probably the best place for me to be. (Consumer 10.)

Thus, the meaning of the inpatient psychiatric unit shifts from a frightening space into one that provides sanctuary and respite from the stressors associated with life in the community when experiencing severe mental illness. Consumers also described their experience of hospitalization as being safe at times and unsafe at others dependent on other factors, discussed below.

Social factors

Here, we describe the inpatient psychiatric unit as a setting for particular social relations, and the impact of these relations on consumers' perceptions of the inpatient psychiatric unit as safe or unsafe.

Interactions with care providers

Consumers described their interactions with care providers as having a significant effect on their perception of the hospital as a safe and therapeutic environment.

Negative experiences of care provision contributed to the inpatient psychiatric unit being experienced as an unsafe place. Consumers absconded, or wanted to abscond, because they felt they were not being helped, or that there was no hope that they would get better, if they stayed in the unit:

> Interviewer: Can I ask why you were desperate to get out?
> Respondent: Because there was no help whatsoever, none whatsoever. (Consumer 9.)

Insufficient communication, a feeling of not being listened to and relationship building was also a factor. One respondent described this lack of communication as follows:

> . . . so you kind of sit there and think 'I wonder what they've put in my notes about me today when clearly they haven't spoken to me all day, how can they know how I'm going?' (Consumer 3.)

Another respondent described her experiences of asking to be held involuntarily under the local mental health act, because she could see that her mental health was deteriorating, and being told she could be voluntary (i.e. allowed to leave any time) and therefore feeling unsafe:

> (If the) doctor says you're fine you can be voluntary then you're not safe. No one wants to go 'please put me away for my own safety, I want to be detained', . . . it's up to the doctor and then when you ask that and say 'can I have this?' they think you don't need it . . . and so I feel often disempowered because no one listens to me when I'm trying to get help . . . (Consumer 11.)

This comment is interesting because it illustrates the interrelationship between contextual factors (being involuntary or voluntary) and the consumer's illness experience on the meaning of the hospital space. The lack of an effective therapeutic relationship was identified as a cause of fear, underpinning the desire to abscond.

Consumers felt that often staff were unavailable, too busy, or disinterested in making time to address their needs:

> . . . you know that you're going to get discharged before you're well enough to actually manage . . . I guess if you feel like there's no hope or no purpose of you being there it's 'why don't I just go home now and I'll deal with the consequences if I live or die' and you're kind of like 'I don't care'. (Consumer 3.)

However, consumers generally viewed inadequate care provision as relating more to the attitudes of the care providers themselves. This included a lack of respect and treating consumers like children. At the same time, consumers pointed to the possibility of a positive therapeutic relationship preventing absconding:

> . . . if they stop being treated the way they are and they get treated like an adult they won't leave, I mean I would stay willingly. If I felt I needed to be detained and they treated me like a human being I would stay. (Consumer 7.)

The above quote is indicative of the impact of the consumers' relationships with staff on their absconding behaviour, and the importance of a therapeutic relationship between staff and consumers.

Interactions with other consumers

Consumers in our study identified feeling fearful of other consumers as a reason for absconding. They described feeling unsafe due to fears of theft and fears for personal safety, including physical violence, bullying, and sexual harassment:

> . . . also another reason why I've absconded is because, some of the male patients (sic) have been sexually, whatever the word is (harassing) . . . and I've been scared. (Consumer 11.)

Consumers also described the effect of being with others who are mentally ill on their perceptions of the psychiatric unit as a safe and therapeutic place. They described the unit as 'not exactly a happy place to be' where people 'do really weird things' (consumer 11), and this can be frightening and lead to an exacerbation of their own mental ill health. For example, one respondent described seeing someone admitted to the unit who had tried to suicide, and making an association between suicide and being in the psychiatric unit:

> . . . and in came an ambulance with one of the fellows who had a day pass, day release, at that stage came back and he was heavily drugged and had his wrists all bandaged up, he'd clearly tried to suicide and that really frightened me, freaked me out and I thought 'hell I'm not going this way', so I took off. (Consumer 2.)

These experiences demonstrate the ways in which the psychiatric unit provides a setting for fearful relationships with other consumers. Furthermore, there is an interconnection between individual factors, such as experiencing severe mental health problems, and social factors, such as the behaviour and experiences of other consumers, which impacts on perceptions of the unit as an unsafe place.

Physical environment

The physical aspects of the psychiatric inpatient unit also had an impact on consumers' experiences of the unit as a safe and therapeutic place. For example, consumers complained about the physical environment of the hospital being too crowded, noisy, too busy, too cold or hot, and ugly, even prison-like. Consumers identified that tranquil, calming surroundings (natural surroundings outdoors and the use of colour indoors) were more conducive to healing.

The physical environment of the hospital furthermore provided varying degrees of privacy, which influenced the perception of the hospital as a safe place. In one instance, the consumer felt that allowing too much privacy made the hospital environment unsafe, in that it offered too many opportunities to abscond and for others to enter the environment who are not supposed to be there. By contrast, privacy was seen as a positive aspect of the physical environment by another consumer, who identified her room as her 'own little sanctuary' (consumer 12).

The physical aspects of the hospital were also described as affecting social relationships, with consumers discussing the influence of shared spaces between men and

women on their feelings of safety (with women in particular feeling unsafe in communal spaces that are shared with men). Furthermore, the physical environment had an impact on the relationship between nurses and consumers, with one respondent stating that the positioning of the nurses' station led to the formation of a 'them and us' relationship, in addition to a lack of interaction and communication:

> Certainly when I was in that situation it was them and us and . . . the nursing staff were the enemy . . . they had the nurses' station in the middle and it was like a garrison and the nurses didn't talk with you at all. (Consumer 4.)

Symbolic environment

In this section, we describe the symbolic aspects of the psychiatric inpatient unit that impacted on consumers' absconding behaviour, particularly in relation to their experiences of a lack of freedom and familiarity/ unfamiliarity with the environment.

Lack of freedom

The consumers discussed the symbolic environment of the inpatient psychiatric unit as prison-like, and described the fear associated with feeling like they were 'being jailed' (consumer 4), 'marshalled' and 'organized' (consumer 2), and denied autonomy:

> Some reasons (for absconding) are probably the feeling of being powerless. To feel that somebody has total control over what you do, when you shower, when you go to bed, when you're allowed out for a smoke has a massive effect on me, massive effect. (Consumer 7.)

Lack of freedom led to feelings of loneliness, isolation, and boredom. Consumers identified that not being free to do what they wanted to do or go and see who they wanted to see, in addition to having no structured activities available or access to open areas, led to absconding. Boredom had a significant impact on the functioning of the hospital as a therapeutic landscape, and was identified by consumers as exacerbating symptoms and further impacting negatively on the hospital as a safe place:

> . . . there's nothing to do . . . you just smoke cigarettes or think you want to go out and do something. (Consumer 11.)

Hospital as a familiar/unfamiliar environment

The psychiatric inpatient unit was described by most consumers as an unfamiliar environment, alien and strange. Lack of familiarity led to the hospital being experienced as a frightening and uncomfortable place to be, resulting in a desire to abscond. The hospital was generally experienced as unfamiliar (and therefore unsafe); however, it could also be experienced as familiar (and therefore safe). Familiarity resulted from knowing the staff and other consumers. Consumers also described feeling safe when hospital routines (what time breakfast is, what time meetings are) were familiar to them. The routine of the unit was perceived and experienced differently. For some, it was an aspect of the lack of freedom experienced in the hospital, while for others it was a marker of the safety of the hospital environment.

Discussion

Findings demonstrate that the main reason the consumers absconded from hospital was feeling unsafe in the hospital environment. The findings highlight the importance of individual (illness experience), social (relations with staff and other consumers), and symbolic (freedom and familiarity) aspects in addition to the physical environment (colour, light, space). Providing a safe environment is recognized as being central to the therapeutic milieu of the psychiatric inpatient unit, including the safety of the consumer from harm from themselves and others, and providing a safe place to talk through issues and know that they will be listened to and respected (Hopkins *et al*. 2009). This is also reflective of the refuge/ asylum function of the hospital in mental health geography discussed by Curtis *et al*. (2009) and Parr (1999).

Findings identify that consumers' experience of others (nurses and other consumers) influenced their perception of the environment as supportive or otherwise. This finding is supported by Wiersma (2008) in his work on the meaning of place (here, hospital) to individuals. Furthermore, feeling safe with other consumers in hospital is a significant issue that has also been identified in other research (Glasby & Lester 2005; Johnson & Delaney 2006; Wood & Pistrang 2004). In this study, consumers felt unsupported and unsafe when staff did not promote a therapeutic environment, and this is again supported by research that has identified that consumers consider safety as an element of the therapeutic interaction (Koivisto *et al*. 2004).

A number of facets contribute to the formation of the hospital as an unsafe place, including experiencing severe mental illness, relationships with staff and consumers, and the physical and symbolic aspects of the hospital environment. While each of these facets can be viewed separately, it is important to understand the ways in which they interconnect in the formation of the hospital as unsafe. Thus, the hospital provides the setting for particular social relationships (between staff and consumers, and between consumers themselves), which are impacted by the physical spaces of the hospital (such as the location of the nurses' station and the availability of shared spaces for men and women), and also by the social conditions in which the hospital functions (such as pressure on beds). These relationships are furthermore impacted on by the consumer's illness experiences and their expectations of the care they will receive while in hospital, as well as the symbolic meaning of hospital in terms of the dichotomy between freedom and familiarity. It is through these interconnections that the acute psychiatric unit sometimes failed to provide a therapeutic space for healing and recovery for consumers, resulting in absconding behaviours.

Our analysis of the inpatient psychiatric unit as a therapeutic landscape supports the findings of other research into consumers' experiences by demonstrating that the hospital is not an intrinsically therapeutic place (Jones *et al*. 2010; Laws 2009; Quirk *et al*. 2004; 2006; Shattell *et al*. 2008). Much has been written about the importance of understanding that therapeutic landscapes are context dependent, and that environments are experienced differently by individuals, where what is therapeutic for one person may not be so for another (Gesler 2005; Milligan & Bingley 2007). This is certainly the case with our study, where the consumers discussed changing perceptions of the hospital landscape as safe/unsafe depending on the personal context of their illness experience, and the social, physical, and symbolic context. In particular, the consumers discussed changes in the meaning of the hospital over time as they came to better understand their illness and with the increasing familiarity of the hospital landscape.

Understanding the relationship between the hospital as a safe place and absconding has important implications for practice. The interconnection between the personal, social, physical, and symbolic aspects of the hospital landscape provides a number of avenues for improving consumers' perceptions of the hospital as a safe place in which to recover. According to Curtis *et al*. (2007), hospital planners and designers most often attend to the physical aspects of the hospital, while neglecting the social and symbolic aspects. The authors recommend attention be paid to these aspects in order to ensure that the psychiatric hospital functions as a therapeutic landscape. A similar point can be made with regard to

absconding. As our study suggests, ensuring that the psychiatric inpatient unit is experienced as therapeutic has the potential to reduce the incidence of absconding. Feeling safe in the therapeutic interaction with staff in the psychiatric inpatient unit is a significant element of consumers' person– place encounter; another is the importance of feeling safe in relation to interactions with other consumers. Consumers' feelings of safety reduced the need to attempt to abscond.

There are a number of recommendations for practice emergent from this study. The first relates to the centrality of the therapeutic relationship between staff and consumers, and the importance of achieving mutual respect, talking to consumers on an equal footing (Curtis *et al*. 2007), and recognizing the legitimacy of the fear inspired by the interaction between the illness experience and the hospital environment (Gilburt *et al*. 2008). Ordinary communication with consumers, showing interest, being with and being there for them, getting to know consumers, and giving information are all possible ways mental health nurses can engage usefully with those in their care (Cleary *et al*. 2012). Mental health nurses can seek out information from patients to establish any potential risk of absconding and associated reasons, and address issues to reduce absconding events. When a consumer returns to an inpatient unit after an absconding event, sensitive engagement with the consumer can address the reason behind the absconding to inform future individualized care.

Heightened awareness by mental health nurses of the potential impact (positively and negatively) of consumers on each others' experiences of hospitalization, management of the ward milieu, and seeking information from consumers about how they feel in the environment can open communication to prevent or at least reduce the likelihood of a consumer absconding. Part of this relationship also involves the provision of a secure environment where consumers can feel safe, which would involve actively addressing the impact of other consumers (such as through the provision of separate communal spaces for women and men) and ensuring a balance between adequate supervision and privacy. Manipulation of the physical space of the acute inpatient unit can be achieved by providing quiet areas and use of sensory modulation (Chalmers *et al*. 2012) as well as maximizing opportunities for consumers to have access to physical exercise, open space, and fresh air. This study has furthermore highlighted the importance of providing meaningful activity to reduce boredom. The provision of a range of diversional and educational programs and activities to consumers is required to reduce consideration of wishing to leave hospital.

Limitations of the study

The study is limited in that it is a small-scale, exploratory study involving a self-selecting group recalling past experiences of absconding. Furthermore, the study is geographically limited to the Australian acute inpatient landscape. Nevertheless, the findings from this study echo other international research and extend understandings about why consumers abscond from inpatient units and how absconding events may be reduced.

Conclusion

In this paper, we have explored the impact of the person– place encounter on absconding from the inpatient psychiatric unit. Absconding is an event that can have serious consequences for consumers and others. Understanding why people abscond can provide valuable information to assist hospitals in keeping consumers safe. By adopting a therapeutic landscape approach, we have been able to demonstrate the impact of the interrelationship between the individual, social, physical, and symbolic aspects of the inpatient psychiatric unit landscape on absconding. Awareness of these aspects can assist mental health nurses to provide individualized care to facilitate a positive consumer experience and reduce the incidence of absconding.

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